Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN2117AGZ	A. BUILDING _____ B. WING _____	C 10/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT THE SEASONS	5165 SUMMIT RIDGE CT RENO, NV 89523

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility from 9/8/10 to 10/7/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for a total of 120 Residential Facility for Group beds: 90 beds for elderly and disabled persons, Category II residents and 30 beds which provide care to persons with Alzheimer's disease, Category II residents. One resident file was reviewed. Complaint #NVN00026343 was substantiated. See Tag Y0645. The following deficiencies were identified:	Y 000		
Y 645 SS=A	449.2704(1)-(5) Rate Agreement NAC 449.2704 The administrator of a residential facility shall, upon request, make the following information available in writing: 1. The basic rate for the services provided by the facility; 2. The schedule for payment; 3. The Services included in the basic rate; 4. The charges for optional services which are not included in the basic rate; and	Y 645		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 645	Continued From page 1 5. The residential facility's policy on refunds of amounts paid but not used. This Regulation is not met as evidenced by: Based on record review on 9/8/10 through 10/7/10, the facility violated the terms of resident's admission agreement regarding a refund in the event of a death (Resident #1). Severity: 1 Scope: 1	Y 645		